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JOINT COMMITTEE ON FINANCE

MEMORANDUM

To: Members
Joint Committee on Finance

From: Senator Alberta Darling
Representative Robin Vos

Date: January 7, 2011

Re: DHS Report to JFC

Attached is a report on Community Options Program (COP) and the Home and Community-Based Waivers (COP-W/CIP II) from the Department of Health Services, pursuant to s. 46.27(11g) and s. 46.277(5m), Stats.

This report is being provided for your information only. No action by the Committee is required. Please feel free to contact us if you have any questions.

Attachments

AD:RV:jm

State of Wisconsin
Department of Health Services

Scott Walker, Governor
Dennis G. Smith, Secretary

January 7, 2011

The Honorable Alberta Darling
Joint Committee on Finance, Co-Chair
State Capitol, Room 317 East
Madison, WI 53702

The Honorable Robin Vos
Joint Committee on Finance, Co-Chair
State Capitol, Room 309 East
Madison, WI 53702

Dear Senator Darling and Representative Vos:

The attached report is submitted to the Legislature pursuant to s.46.27 (11g) and s.46.277 (5m) of the Wisconsin statutes, which require the Department of Health Services to submit an annual report for the Community Options Program (COP) and the Home and Community-Based Waivers (COP-W/CIP II). The attached report describes the persons served, program expenditures, and services delivered through the COP, COP-Waiver and CIP II programs in calendar year 2009.

The Community Options Program provides services to people who are elderly or who have a physical, developmental or mental disability, and is coordinated with all of Wisconsin's Medicaid Home and Community-Based Waivers including Family Care. With the Department's oversight, county agencies are able to ensure that a comprehensive and individualized care plan is provided, while maintaining program flexibility and integrity, and maximizing federal matching funds.

Sincerely,

Dennis G. Smith

Dennis G. Smith
Secretary

Attachment

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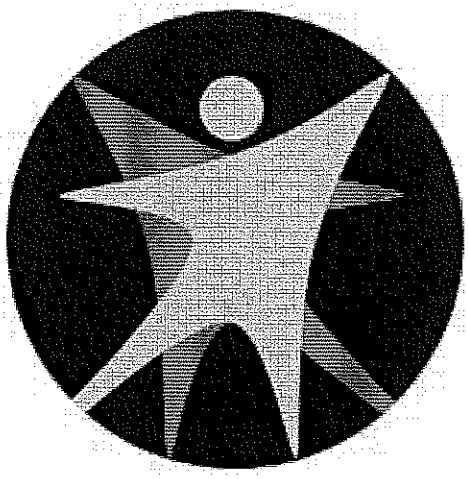
dhs.wisconsin.gov

Report to the Legislature

Community Options Program

Community Options Program Waiver

Calendar Year 2009



Department of Health Services
Division of Long Term Care
Bureau of Long Term Support

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INTRODUCTION

This report is submitted pursuant to s. 46.27(11g) and s. 46.277(5m), of the Wisconsin Statutes, which requires summary reporting on state funds appropriated in the biennial budget process for the Community Options Program. The Community Options Program (also known as COP-Regular or Classic COP) serves all client groups in need of long-term care and is entirely state-funded.

The Community Options Program (COP) began in 1981. The purpose of the program is to provide a home and community-based alternative to nursing home care. The Community Options Program offers community-based choices for older people and people with disabilities at a lower cost to the state than institutional choices for long-term care. In 1986, Wisconsin received a federal Medicaid Home and Community-Based Waiver for people who are elderly or have a physical disability, which allows the state to obtain federal matching funds for COP. The Community Options Program serves a limited number of people and is not an entitlement.

The state-funded Community Options Program – "Regular" serves people who are elderly or who have a physical or developmental disability or substantial mental health needs. The COP Medicaid waiver serves people who are elderly or have a physical disability. This includes the Community Options Program-Waiver (COP-W) and the Community Integration Program II (CIP II). Other Medicaid waiver programs are targeted to specific populations in need of long-term care services. Community Integration Program 1A (CIP 1A) and Community Integration Program 1B (CIP 1B) supports the community needs for long-term care participants with developmental disabilities. Brain Injury Waiver (BIW) serves individuals who have received brain injury rehabilitation. In addition, the Children's Long Term Support (CLTS) waivers serve children and young adults under the age of 22 with developmental disabilities, physical disabilities and severe emotional disturbances including autism.

Highlights for Calendar Year 2009 include:

- COP and home and community based waivers served a total of 21,067 citizens.
- Over half of all individuals served had a developmental disability, approximately 26% of individuals were elderly and 14% of persons had a physical disability. The remaining individuals received services due to a mental illness or alcohol and/or drug abuse.
- $455 million all funds was expended to serve individuals in COP and all waiver programs.
- The *average* daily cost of care for participants in CIP II and COP-W was $90.77. In contrast, the *average* daily cost of care for people in nursing homes, at the same average level of care, was $120.29.
- Seventy-one percent of COP and waiver participants received care in their own homes or apartments; the remaining individuals lived in substitute care residences such as a community-based residential facility, adult family home or child foster care.
- During 2009, 4,247 persons transitioned to Family Care (FC), FC Partnership or the IRIS self-directed waiver. These transfers accounted for 20% of the total number served and 72% of participant case closures.

Individuals who use waiver services are also eligible for the Medicaid fee-for-service ("card") benefits, and must use the Medicaid card before relying on the waivers to fill gaps in care. Participants in CIP II and COP-W used $60,279,739 in benefits from their Medicaid card. The largest expenditures were for personal care services ($29 million) and home health care ($18 million).

The statutes also permit COP funds to be used as non-federal match to support the Medicaid waiver programs. The federal government grants waivers of Medicaid rules to permit states to provide long-term care in community settings to a population that qualifies for Medicaid coverage of nursing home care. State funds are matched by federal Medicaid dollars at a ratio of about 40/60.

TABLE 1 - Participants Served by Programs During 2009 with COP and all Waivers

Program Category	Elderly	PD	DD	SMI	AODA	Medicaid Waiver Funds Only	Waiver w/Additional COP	Total Served Unduplicated
COP-W								**3,814**
Waiver Only	1,729	990				2,719		
Waiver/COP	881	214					1,095	
CIP II								**3,663**
Waiver Only	1,388	1,157				2,545		
Waiver/COP	709	409					1,118	
Sub Total COP-W/CIP II	**4,707**	**2,770**				**5,264**	**2,213**	**7,477**
CIP 1A								**833**
Waiver Only	51		758			809		
Waiver/COP	2		22				24	
CIP 1B Regular								**2,421**
Waiver Only	255		2,095			2,350		
Waiver/COP	11		60				71	
CIP 1B COP Match								**1,636**
Waiver/COP for match only	61		1,489			1,550		
COP match waiver w/other COP	15		71				86	
CIP 1B Other Match								**3,158**
Waiver/other for match	185		2,942			3,127		
Waiver/COP	1		30				31	
Brain Injury Waiver								**148**
Waiver Only	3		92	47		142		
Waiver/COP			5	1			6	
Brain Injury COP Match								**8**
Waiver/COP for match only			3	3		6		
COP match waiver w/other COP			1	1			2	
Brain Injury Waiver Other Match								**59**
Waiver/other for match	3		37	19		59		
Waiver/COP								
Sub Total DD Waivers	**587**		**7,605**	**71**		**8,043**	**220**	**8,263**
CLTS								**3,084**
Waiver Only		100	2,708	255		3,063		
Waiver/COP		3	12	6			21	
CLTS COP Match								**391**
Waiver/COP for match only		43	226	90		359		
COP match waiver w/other COP		4	21	7			32	
CLTS Other Match								
Waiver/other for match		41	571	208		820		**830**
Waiver/COP		2	3	5			10	
Sub Total CLTS Waivers		**193**	**3,541**	**871**		**4,242**	**63**	**4,305**
COR Waiver				**5**			**5**	**5**
COP Only Participants	**156**	**29**	**15**	**811**	**6**		**1,017**	**1,017**
Totals by Target Population	**5,450**	**2,992**	**11,161**	**1,458**	**6**	**17,549**	**3,518**	**21,067**
% Served by Target Population	**25.8%**	**14.2%**	**53.0%**	**6.9%**	**<.01%**	**83.3%**	**16.7%**	

NOTE: Participants with a dual diagnosis are counted under the funding program. Source: 2009 HSRS.

- Total unduplicated participants served in 2009 – 21,067
- Total participants who were served by a Medicaid waiver only (no COP funds) - 17,549
- Total Medicaid waiver participants who also received COP funding in CY 2009 – 2,501
- Total participants who received only COP funding (not Medicaid eligible) - 1,017.
- All participants who received either pure COP or COP to supplement waiver funds – 3,518
- Total participants served with COP and COP-W funds - 6,237

PARTICIPANTS SERVED BY TARGET GROUP

The Community Options Program and all the home and community-based waivers combined served a total of 21,067 persons. The table below illustrates participants served in 2009 with COP and Medicaid waiver funding by target group.

TABLE 2
Participants Served by Target Group During 2009 with COP and All Waivers

Target Group	COP Only	COP-W	Subtotal COP Only, COP-W	All Other COP Used as Match	CIP II	Subtotal COP Only, COP-W, Other COP, CIP II	CIP 1, CLTS, BIW, COR	GRAND TOTAL
Elderly	156 15.34%	2,610 68.43%	2,766 57.26%	738 52.49%	1,388 54.54%	4,892 55.70%	558 4.54%	5,450 25.87%
PD	29 2.85%	1,204 31.57%	1,233 25.52%	418 29.73%	1,157 45.46%	2,808 31.97%	184 1.50%	2,992 14.20%
DD	15 1.47%	0 0%	15 0.31%	225 16.00%	0 0%	240 2.73%	10,921 88.90%	11,161 52.98%
SMI	811 79.74%	0 0%	811 16.79%	25 1.78%	0 0%	836 9.52%	622 5.06%	1,458 6.92%
AODA	6 0.59%	0 0%	6 0.12%	0 0%	0 0%	6 0.07%	0 0%	6 0.03%
Total	1,017 4.83%	3,814 18.10%	4,831 22.93%	1,406 6.67%	2,545 12.08%	8,782 41.69%	12,285 58.31%	21,067 100.0%

Note: Totals may not equal 100% due to rounding. Source: 2009 HSRS.

- 5,450 or 26% were elderly;
- 2,992 or 14% were persons with physical disabilities (PD);
- 11,161 or 53% were persons with developmental disabilities (DD);
- 1,458 or 7% were persons with severe mental illness (SMI); and
- 6 or less than 1% were persons with alcohol and/or drug abuse (AODA)
-

FIGURE 1
Participants Served by Target Group During 2009 with COP and All Waivers

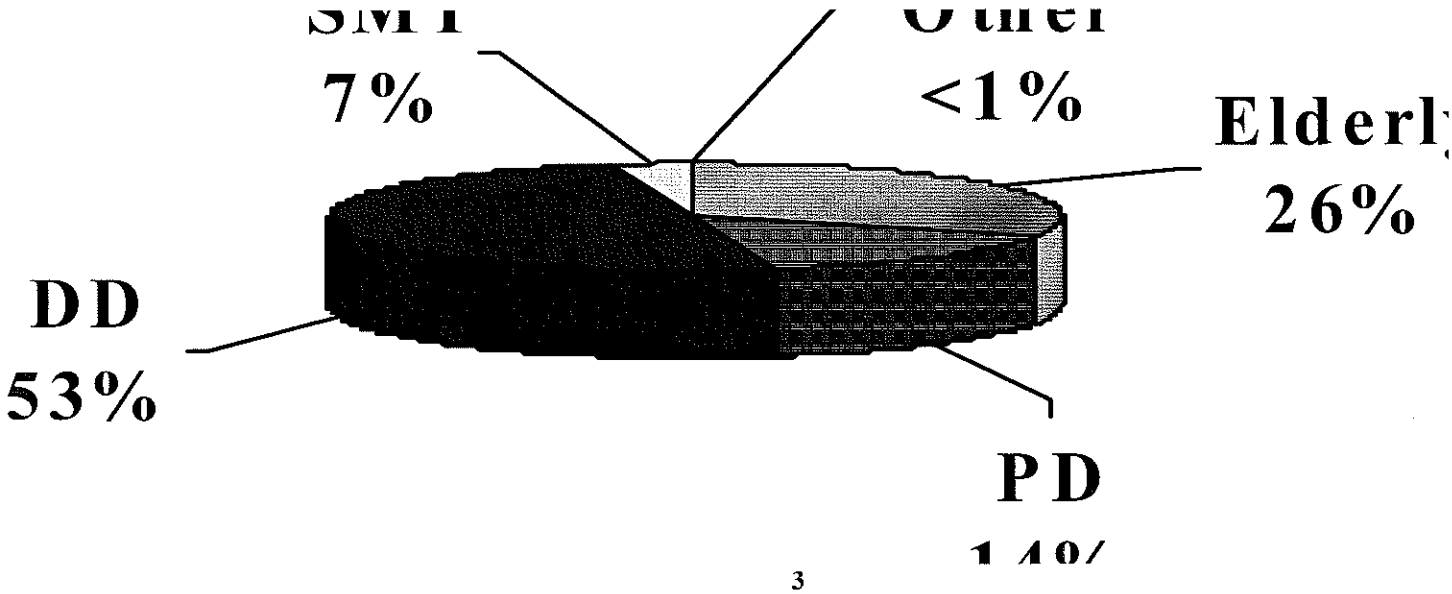
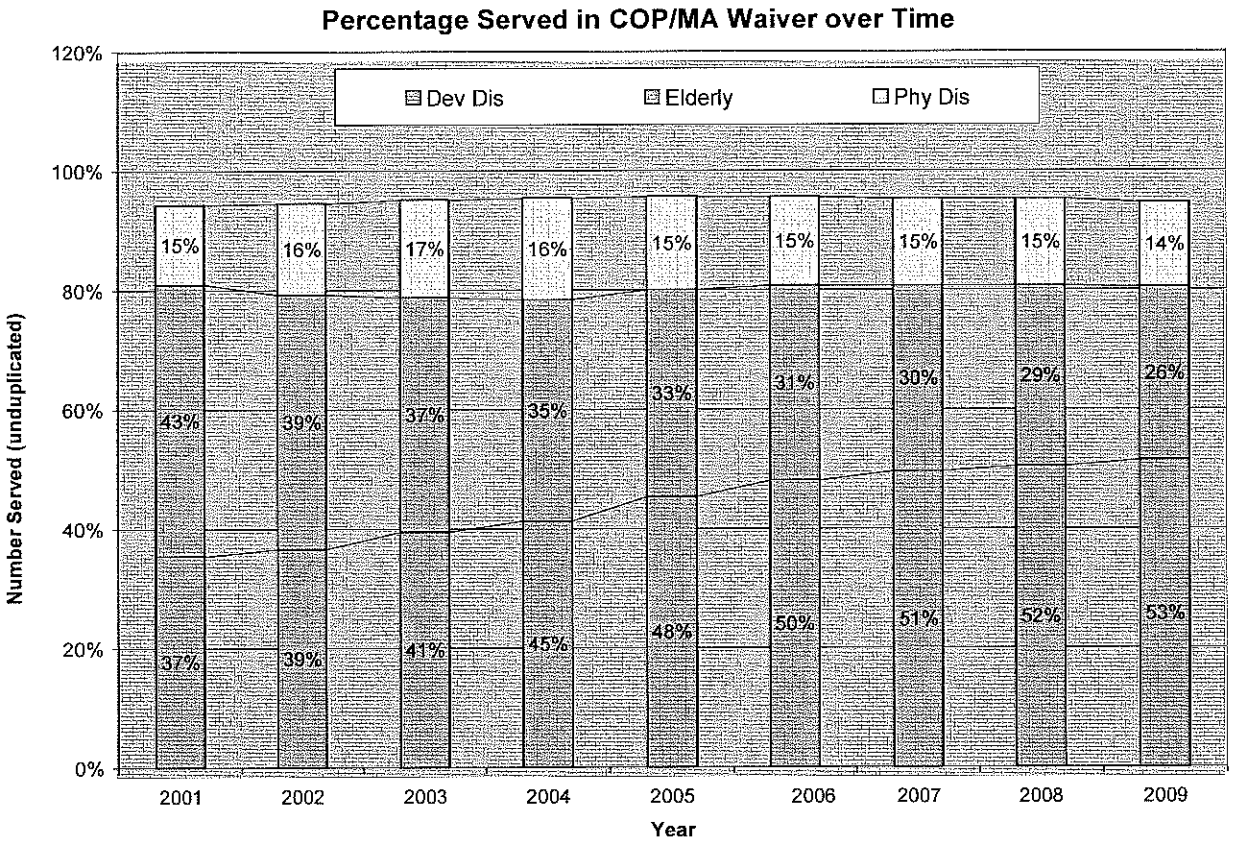


FIGURE 2



ASSESSMENTS, CARE PLANS AND PERSONS SERVED

The Community Options Program lead agencies provide eligible individuals with an assessment and care plan that identifies equipment, home modifications and services that might be available to assist them in their own homes and communities. During the assessment process, a social worker and other appropriate professionals assess each individual's unique characteristics, medical condition, living environment, lifestyle preferences and choices. The individual and the care manager develop a plan for a comprehensive package of services, which integrates and supports the informal and unpaid assistance available from family and friends. This care plan incorporates individual choices and preferences for the type and arrangement of services. Depending upon available income and assets, the individual may be responsible for paying some or all of the costs for services in their care plan. In 2009, 3,143 assessments were conducted, and 1,799 care plans were prepared.

NEW PERSONS

Figure 3 illustrates the target group distribution of the 2,719 new persons served during 2009. The majority of the new participants served in 2009 were individuals with a developmental disability. Clients are considered new if they have services and costs in the current year and no long-term support services of any type in the prior year.

FIGURE 3
New Persons Receiving Services by Target Group in 2009
For COP and All Waivers

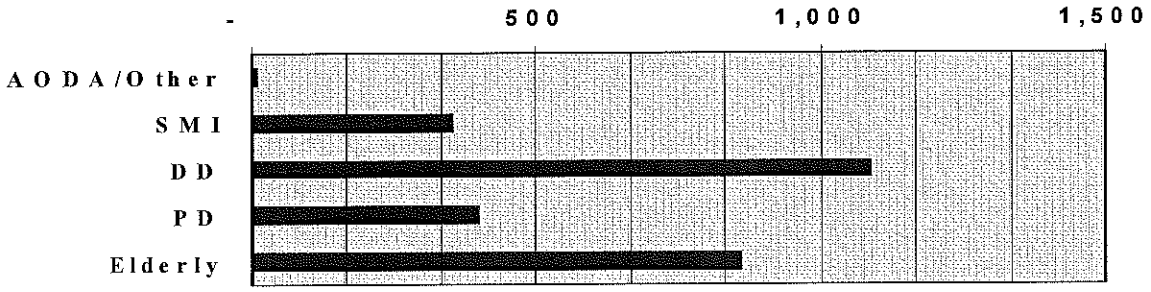


TABLE 3
New Persons Receiving Services by Age in 2009
For COP and All Waivers

	Elderly	PD	DD	SMI	AODA/Other	TOTAL
<18 yrs.	NA	44	375	160	1	580
18 – 64 yrs.	NA	358	715	193	10	1,276
65+ yrs.	863	NA	NA	NA	0	863
TOTAL	863(31.7%)	402 (14.8%)	1,090 (40.1%)	353 (13.0%)	11 (.4%)	2,719

Source: 2009 HSRS.

PARTICIPANT CASE CLOSURES

Table 4 illustrates the number of participants in each target group who left the program in 2009 for various reasons. Approximately 5,888 or twenty-eight percent of all people participating in COP and all Waivers, were closed for services during 2009. A person's death accounts for about 23 percent of elderly service closures and 14 percent of closures of persons with physical disabilities. Moving to an institution accounts for approximately 5 percent of all closures and was 12 percent of closures for the elderly population. Transferring in 2009 to Family Care (FC), FC Partnership or the self-directed supports IRIS program accounts for approximately 72 percent of all closures and was 88 percent for persons with developmental disabilities.

TABLE 4
Reasons for Participant Case Closures for COP and All Waivers

	Elderly	PD	DD	SMI	AODA	Other	Total
Person Died	516	123	89	16	1	0	745
Transferred to or Preferred Nursing Home Care	256	39	11	11	0	0	317
No Longer Income or Care Level Eligible	24	28	59	32	1	0	144
Moved	39	34	53	13	0	0	139
Voluntarily Ended Services	22	32	65	52	0	0	171
Other Funding Used for Services	1	5	11	8	0	0	25
Reside in ICF-MR/IMD Center	0	0	2	4	0	0	6
Ineligible living arrangement	19	4	14	18	0	0	55
Inadequate Service/Support	4	4	6	9	1	0	24
Transferred to Family Care (FC), FC Partnership or the IRIS program	1,318	614	2,238	67	2	8	4,247
Other	7	3	4	1	0	0	15
Total Cases Closed (all reasons)	**2,206**	**886**	**2,552**	**231**	**5**	**8**	**5,888**

Source: 2009 HSRS.

PARTICIPANT TURNOVER RATE

Turnover is defined as the number of new people who need to be enrolled for services in order to keep the caseload constant. For example, a local program may need to serve 125 persons during a year to maintain an average ongoing caseload of 100, and would have had a turnover of 25 participants. The turnover rate equals the amount of turnover divided by the total caseload. In this example, the turnover rate is 25 percent.

Table 5 illustrates the number of people closed for services during 2009 divided by the caseload size on December 31, 2008 for each target group. The shaded row of Table 5 below shows the turnover rate for each target group. Please note: turnover in 2009 included transfers to Family Care and Partnership.

TABLE 5
Calculation of Turnover by Target Group for COP and All Waivers

	Elderly	PD	DD	SMI	AODA	Total
All Persons Served During 2009	5,420	3,026	11,072	1,525	24	21,067
Point-in-Time Number of Persons Served on December 31, 2009	3,222	2,109	8,881	1,286	18	15,516
Number of Closures During 2009 (Includes Transfers to the Family Care Program)	2,206	886	2,552	239	5	5,888
Point-in-Time Number of Persons active on December 31, 2008 Caseload Size)	4,753	2,788	10,974	1,214	19	19,748
Turnover Rate for the Above Case Closures	**46%**	**32%**	**23%**	**20%**	**n/a**	**30%**

Source: 2009 HSRS.

COP FUNDING FOR EXCEPTIONAL NEEDS

The statewide Community Options Program also includes funds for exceptional needs. The Department may carry forward to the next fiscal year any COP and COP-W GPR funds allocated but not spent by December 31 of each year (s. 46.27(7)(g), Wis. Stats.). These exceptional funds are made available to applicant counties for the improvement or expansion of long-term community support services for COP eligible people. Services may include:

a) start-up costs for developing needed services for eligible target groups;
b) home modifications for COP or Waiver eligible participants including ramps;
c) purchase of medical services and medical equipment or other specially adapted equipment; and
d) vehicle modifications.

In 2009, funds for exceptional needs were awarded to 45 counties and served 230 individuals with developmental disabilities, physical disabilities, the frail elderly and children. Awards were made for 107 home repairs and modifications including 18 ramps, mobility lifts, ceiling lifts, roll-in showers, raised toilets, wider hallways and doors, door openers, environmental control systems and other items. Fifty-two awards were made for adapted mobility equipment such as wheelchairs and scooters not covered by Medicaid, 37 vehicle modifications and 19 awards were for dental work.

PARTICIPANT DEMOGRAPHIC AND SERVICE PROFILES

TABLE 6 - COP and All Waiver Participants by Race/Ethnic Background

PARTICIPANTS BY RACE/ETHNIC BACKGROUND	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Caucasian	5,088	2,376	9,785	1,331	31	18,611	88%
African American	91	472	725	121	2	1,411	7%
Hispanic	33	72	271	27	0	403	2%
American Indian/Alaska Native	102	73	132	23	2	332	2%
Asian/Pacific Islander	103	33	152	12	0	300	1%
Unknown	3	0	7	0	0	10	<1%
TOTAL	5,420	3,026	11,072	1,514	35	21,067	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2009 HSRS.

TABLE 7 - COP and All Waiver Participants who Relocated/Diverted from Institutions

RELOCATED/DIVERTED	Number	Percent
Diverted from Entering any Institution	17,829	84%
Relocated from General Nursing Home	1,688	8%
Relocated from ICF/MR	1,395	7%
Relocated from Brain Injury Rehab Unit	153	1%
Other	2	<1%
TOTAL	21,067	100%

NOTE: Some totals may not equal 100% due to rounding. Source: 2009 HSRS.

TABLE 8 - COP and All Waiver Participants by Gender

PARTICIPANTS BY GENDER	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Female	3,930	1,576	4,296	630	17	10,449	49.6%
Male	1,490	1,450	6,776	884	18	10,618	50.4%
TOTAL	5,420	3,026	11,072	1,514	35	21,067	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2009 HSRS.

TABLE 9 - COP and All Waiver Participants by Age

PARTICIPANTS BY AGE	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Under 18 years	0	172	3,248	533	1	3,954	19%
18 – 64 years	0	2,854	7,824	981	34	11,693	56%
65 – 74 years	1,721	0	0	0	0	1,721	8%
75 – 84 years	1,827	0	0	0	0	1,827	9%
85 years and over	1,872	0	0	0	0	1,872	9%
TOTAL	5,420	3,026	11,072	1,514	35	21,067	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2009 HSRS.

TABLE 10 - COP and All Waiver Participants by Marital Status

PARTICIPANTS BY MARITAL STATUS	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Widow/Widower	2,313	96	25	13	1	2,448	12 %
Never Married	1,036	1,487	10,656	1,235	12	14,426	68 %
Married	1,021	551	119	39	6	1,736	8 %
Divorced/Separated	908	819	121	193	15	2,056	10 %
Other	142	73	151	34	1	401	2 %
TOTAL	5,20	3,026	11,072	1,514	35	21,067	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2009 HSRS.

TABLE 11 - COP and All Waiver Participants by Natural Support Source

PARTICIPANTS BY NATURAL SUPPORT SOURCE	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Adult Child	2,627	371	17	37	8	3,060	15%
Non-Relative	673	603	1,430	298	8	3,012	14%
Spouse	782	471	78	28	5	1,364	7%
Parent	97	912	7,785	742	4	9,540	45%
Other Relative	851	463	1,322	157	7	2,800	13%
No Primary Support	390	206	440	252	3	1,291	6%
TOTAL						21,067	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2009 HSRS.

TABLE 12 - COP and All Waiver Participants by Living Arrangement

PARTICIPANTS BY LIVING ARRANGEMENT	Elderly	PD	DD	SMI	AODA Other	Total Participants	
Living with Immediate Family	1,319	1,220	6,131	517	7	9,194	44%
Living with Others with Attendant Care	850	359	2,123	292	10	3,634	17%
Living with Others	1,063	360	1,668	342	9	3,442	16%
Living Alone	1,745	664	555	303	7	3,274	16%
Living Alone with Attendant Care	286	205	336	30	2	859	4%
Living with Immediate Family with Attendant Care	92	132	131	4	0	359	2%
Living with Extended Family	51	61	112	22	0	246	1%
Living with Extended Family with Attendant Care	8	16	11	2	0	37	<1%
Transient Housing Situation	5	7	2	2	0	16	<1%
Other	1	2	3	0	0	6	<1%
TOTAL	5,420	3,026	11,072	1,514	35	21,067	100%

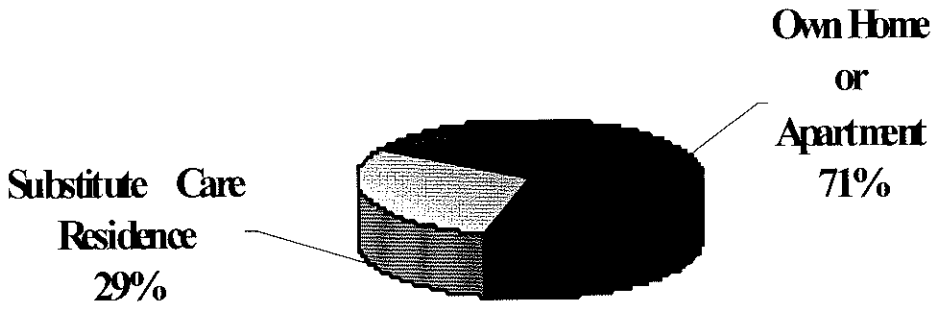
NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2009 HSRS.

TABLE 13 - COP and All Waiver Participants by Type of Residence

PARTICIPANTS BY TYPE OF RESIDENCE	Elderly	PD	DD	SMI	AODA Other	Total Participants	
Adoptive Home	0	1	71	26	0	98	<1%
Adult Family Home (AFH)	398	159	1,770	126	6	2,459	12%
Brain Injury Rehab Unit	0	9	1	0	0	10	<1%
Child Group Home	0	1	2	4	0	7	<1%
Community Based Residential Facility (CBRF)	1,427	260	995	296	13	2,991	14%
Foster Home	0	10	184	154	0	348	2%
ICF/MR: Not State Center	0	0	0	0	0	0	0%
Nursing Home	5	0	1	0	0	6	<1%
Other Living Arrangement	0	0	0	0	0	0	0%
Own Home or Apartment	3,474	2,549	8,023	877	16	14,939	71%
Residential Care Apartment Complex (RCAC)	107	27	0	0	0	134	1%
Residential Care Center (RCC)	0	0	4	4	0	8	<1%
Shelter Care Facility	0	1	5	4	0	10	<1%
State DD Center	0	0	0	0	0	0	0%
Supervised Community Living	8	9	15	23	0	55	<1%
Unknown	1	0	1	0	0	2	<1%
TOTAL	5,420	3,026	11,072	1,514	35	21,067	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2009 HSRS.

FIGURE 4
Percentage of Participants Living in Own Home or Substitute Care Residence



FUNDING OF COMMUNITY LONG-TERM CARE BY TARGET GROUP

A total of $435,469,997 (federal waiver and state funds) was spent in 2009 through the Community Options Program and all long-term care Medicaid Home and Community-Based Services Waivers. As a publicly-funded and managed program for community long-term care, COP-Regular contributes about 9 percent of the overall total. COP-Regular and COP-Waiver together contribute 10 percent of the overall total. These figures do not include funds spent under the fee-for-service (non-waiver) Medicaid program.

TABLE 14
COP and All Waivers
Funding of Community Long-Term Care by Target Group in 2009

Target Group	COP-Regular	COP-W	Subtotal COP-Regular, COP-W	CIP II, COR	Subtotal COP-Regular, COP-W, CIP II	CIP 1, CLTS*, BIW	GRAND TOTAL
Elderly	5,392,625 13%	28,069,389 65%	33,462,014 40%	29,424,710 47%	62,886,724 43%		62,886,724 14%
PD	2,643,004 7%	15,180,825 35%	17,823,829 21%	33,324,907 53%	51,148,736 35%	2,309,547 1%	53,458,283 12%
DD	20,006,131 50%		20,006,131 24%		20,006,131 14%	271,332,434 94%	291,338,565 67%
SMI	12,150,154 30%		12,150,154 15%		12,150,154 8%	15,559,426 5%	27,709,580 6%
AODA	76,845 <1%		76,845 <1%		76,845 <1%		76,845 <1%
Other	0.00 0.0%		0.00 0.0%		0.00 0.0%		0.00 0.0%
Total	$40,268,759 9%	$43,250,214 10%	$83,518,973 19%	$62,749,617 14%	$146,268,590 34%	$289,201,407 66%	$435,469,997** 100%

Source: 2009 HSRS and Reconciliation Schedules.
*Children's waivers serve children with a physical disability, a developmental disability and those children who have a severe mental illness.
** Not included is an additional $1, 008,516 in COP that was spent on "Family Care" expansion and $104,495 on quality assurance.

- The elderly received 14% of the funds;
- Persons with physical disabilities (PD) received 12% of the funds;
- Persons with developmental disabilities (DD) received 67% of the funds;
- Persons with severe mental illness (SMI) received 6% of the funds; and
- Persons with alcohol and/or drug abuse (AODA) or other conditions received less than 1% of the funds.

FIGURE 5
Total COP and Waivers Spending by Target Group

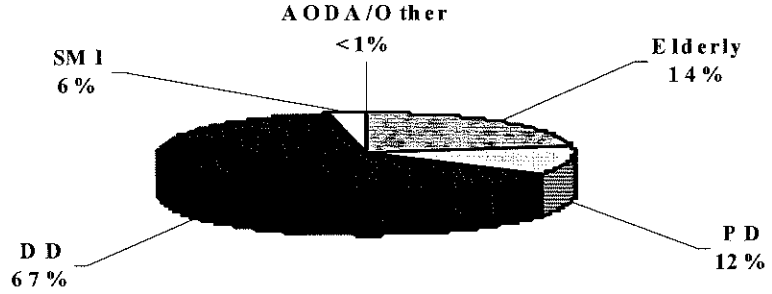
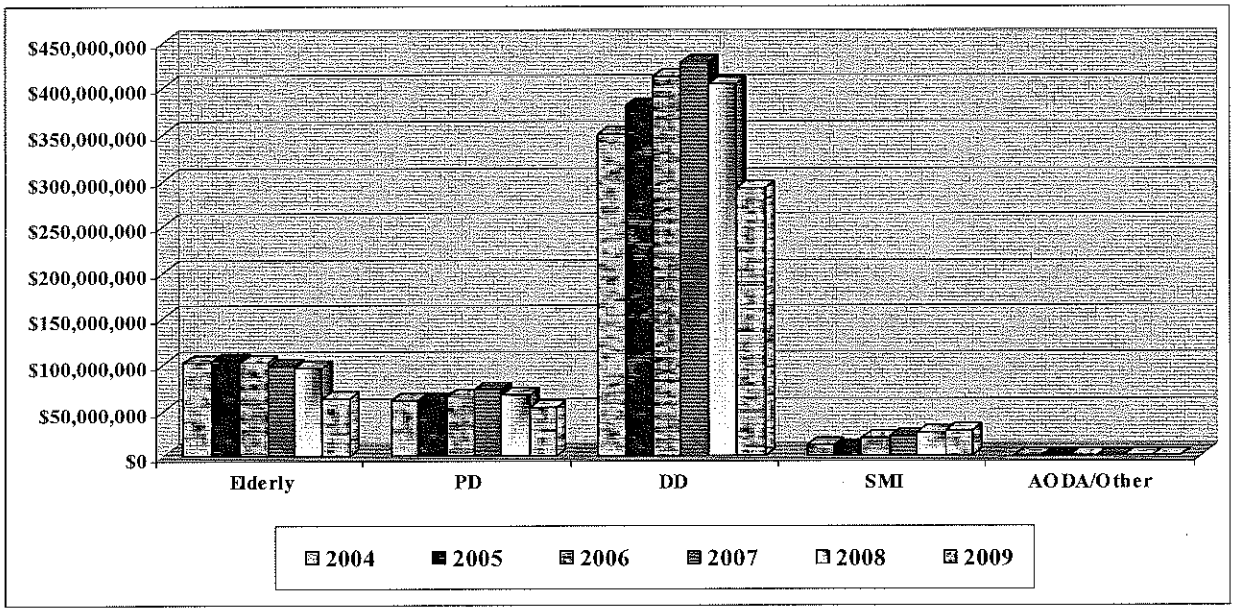


Figure 6 illustrates spending for participants by target groups. The "elderly" category includes all persons age 65 or older regardless of type of disability. All other participants are younger than 65. All participants have a need for a level of care equivalent to a nursing home care level.

FIGURE 6
History of Expenditures for Community Long Term Care by Target Group 2004 – 2009



Source: 2009 HSRS and Reconciliation Schedules.

HOW COP-REGULAR IS USED
Table 15 – Use of COP Regular

Target Group	COP Only	Supplemental COP (gap filling)	Additional GPR Match for Waivers	Admin, Special Projects, Risk Reserve	Assessments And Plans	Total Percent of COP-R Reported
Elderly	12.7%	57.6%	2.6%	22.3%	42.1%	13.4%
PD	1.8%	31.8%	2.8%	9.1%	26.8%	6.6%
DD	0.9%	10.3%	88.6%	10.4%	23.1%	49.7%
SMI	84.0%	0.3%	6.0%	57.8%	7.7%	30.2%
AODA/Other	0.6%	0.0%	0.0%	0.4%	0.3%	0.2%
TOTAL	28.9%	10.2%	53.1%	4.1%	3.6%	100%
Costs Reported*	$13,251,327	$4,652,588	$24,322,079	$1,896,335	$1,660,514	$45,782,843*

*Note: Reflects allowable costs reported on HSRS; however, actual reimbursement was $40,268,759.
Not included is an additional $1, 008,516 in COP that was spent on "Family Care" expansion and $104,495 on quality assurance.

- 29 percent of the total COP-Regular funds were used for services for COP only participants, 84 percent of whom are persons with a severe mental illness.
- 10 percent of COP-Regular was used for current waiver participants to provide services that could not be paid for with waiver funds.
- 4 percent was used for program and service coordination.
- 4 percent of COP-Regular funds were used to conduct assessments and develop care plans.

$24.3 million was used as match to serve more people or for increased service costs for existing participants. Of the funds used for additional match, $21.5 million was used for persons with developmental disabilities. For persons who are elderly or have physical disabilities, $890,065 of COP-Regular funds were used as match to expand the COP-W program and $141,111 COP-Regular funding was used to fund the match for CIP II federal dollars when average costs exceeded the allowable reimbursement rate. In addition, $3.2 million of COP-Regular funding was used to provide support for the new Children's Long Term Support waiver.

CIP II AND COP-W SERVICES

Community Integration Program II and COP-Waiver participants utilize services federally authorized through the Medicaid waiver application and services traditionally available to all Medicaid recipients through the state's Medicaid Plan (e.g., card services). State Medicaid Plan services are provided to all Medicaid recipients eligible for a Medicaid card. The Medicaid Plan services are generally for acute medical care. Waiver services generally focus on community-based supports. Since both types of services are needed to maintain individuals in the community, expenditures for both types must be combined to determine the total public cost of serving waiver participants.

State statutes require use of Medicaid waiver funds only for expenses not covered in the Medicaid program. The Medicaid card services received, the waiver services provided, the total costs for each service and the service utilization rates are outlined in tables 16, 17 and 18. The total cost of Medicaid fee-for-service card costs (not including nursing home costs) for these waiver participants was $60,279,739 (Table 18).

TABLE 16
2009 Total Medicaid Costs for CIP II and COP-W Recipients

Total CIP II and COP-W Service Costs	$107,849,838
Total Medicaid Card Service and Nursing Home Costs while in Waiver Status	$60,279,739
Total 2009 Medicaid Expenditures for CIP II and COP-W Recipients	**$168,129,577**

Source: 2009 Federal 372 Report.

Costs of care, services and environmental adaptations for waiver participants are always a combination of Medicaid State Plan benefits and Medicaid Home and Community Based Services waiver benefits. The coordination of benefits across the program is a key component of the Community Options Program and the waivers.

TABLE 17
2009 CIP II and COP-W Service Utilization and Costs

CIP II and COP-W Service Categories	Rate of Participant Utilization (%)	Cost	Percent of Total Waiver Costs
Care Management	100.00	$14,249,199	13.21
Supportive Home Care/Personal Care	76.53	37,621,411	34.88
Adult Family Home	4.79	8,221,025	7.62
Residential Care Apartment Complex	2.34	2,013,810	1.87
Community Based Residential Facility	26.45	34,123,258	31.64
Respite Care	3.41	829,071	0.77
Adult Day Care	3.34	1,402,227	1.30
Day Services	2.15	1,332,328	1.24
Daily Living Skills Training	0.76	247,694	0.23
Counseling and Therapies	3.53	425,787	0.39
Skilled Nursing	1.74	191,567	0.18
Transportation	24.17	1,577,538	1.46
Personal Emergency Response System	36.82	680,999	0.63
Adaptive Equipment	13.37	844,951	0.78
Communication Aids	1.20	48,781	0.05
Housing Start-up	.74	45,861	0.04
Vocational Futures Planning	.08	11,478	0.01
Medical Supplies	23.62	811,007	0.75
Home Modifications	3.28	914,062	0.85
Home Delivered Meals	23.46	1,998,545	1.85
Financial management Services	6.98	259,239	0.24
Total Medicaid Waiver Service Costs		**$107,849,838**	

Note: Totals may not equal 100% due to rounding. Source: 2009 Federal 372 Report.

TABLE 18
2009 CIP II and COP-W Medicaid Card Service Utilization

Medicaid State Plan Benefits Categories	Rate of Participant Utilization (%)	Cost	Percent of Total Card Costs
Inpatient Hospital	0.04%	$65,150	0.11%
Physician (Physician Services, Clinic Services – including outpatient Mental Health)	77.50%	$3,006,287	4.99%
Outpatient Hospital	12.96%	$1,201,888	1.99%
Lab and X-ray	21.48%	$705,627	1.17%
Prescription Drugs	63.47%	$5,471,779	9.08%
Transportation (Ambulance and Non-Emergency Specialized Motor Vehicle)	31.70%	$1,602,423	2.66%
Therapies (Physical Therapy, Speech and Hearing Therapy, Occupational Therapy, Restorative Care Therapy, Rehabilitative Therapy)	5.76%	$194,631	0.32%
Dental Services	18.74%	$344,625	0.57%
Nursing (Nurse Practitioner, Nursing Services)	0.71%	$6,877,009	11.41%
Home Health, Supplies & Equipment (Home Health Therapy, Home Health Aide, Home Health Nursing, Enteral Nutrition, Disposable Supplies, Other Durable Medical Equipment, Hearing Aids)	14.95%	$5,774,301	9.58%
Personal Care (Personal Care, Personal Care Supervisory Services)	37.61%	$29,286,130	48.58%
All Other (Other Practitioners Services, Family Planning Services, HealthCheck/EPSDT, Rural Health Clinic Services, Home Health Private Duty Nursing – Vent, Other Care, Hospice, Community Support Program)	79.67%	$5,749,889	9.54%
Total Medicaid State Plan Benefit Costs for Waiver Recipients		**$60,279,739**	

Notes: Totals may not equal 100% due to rounding. Source: 2009 Federal 372 Report.

PUBLIC FUNDING AND COST COMPARISON OF MEDICAID WAIVER AND MEDICAID NURSING HOME CARE

In addition to Medicaid-funded services, many waiver participants receive other public funds that can be used to help pay for long-term care costs. To provide an adequate comparison of the cost of serving persons through the Medicaid waiver versus the cost of meeting individuals' long-term support needs in nursing homes, an analysis of total public funding used by each group was completed. Table 19 below indicates total public funds on an average daily basis for nursing home and waiver care.

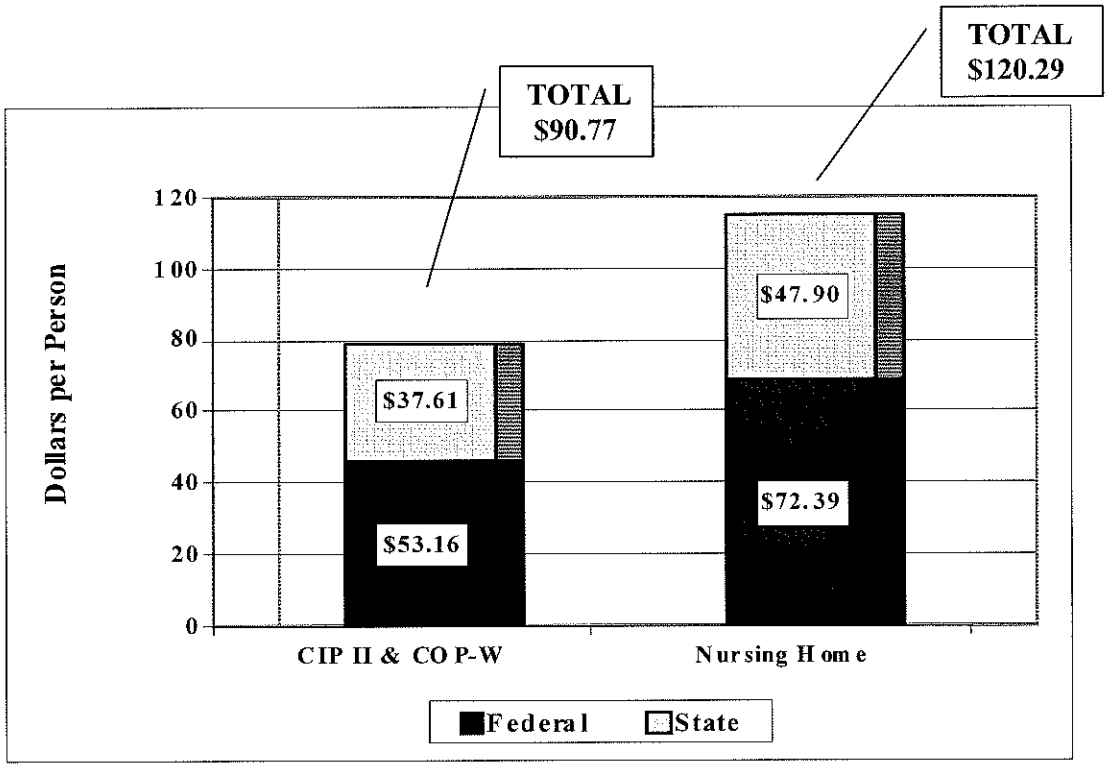
TABLE 19
2009 Average Public Costs for CIP II & COP-W Participants vs. Nursing Home Residents
Average Cost per Person per Day

		Community Care Costs			Nursing Home Costs			Difference		
Year	Cost Category	Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
2009	Medicaid Program Per Diem	$56.02	$22.31	$33.71	$115.48	$45.98	$69.50			
	Medicaid Card	32.32	12.87	19.45	4.81	1.92	2.89			
	Medicaid Costs Subtotal[2]	$88.34	$35.18	$53.16	$120.29	$47.90	$72.39	$31.95	$12.72	$19.23
	COP – Services w/Admin.	2.14	2.14	0.00	n/a[3]	n/a[3]	n/a[3]			
	COP – Assessments & Plans	0.29	0.29	0.00	n/a[3]	n/a[3]	n/a[3]			
	Total	**$90.77**	**$37.61**	**$53.16**	**$120.29**	**$47.90**	**$72.39**	**$29.52**	**$10.29**	**$19.23**

Source: 2009 HSRS and 2009 Federal 372 Report.

When all public costs are counted, expenses for CIP II and COP-W participants averaged $90.77 per person per day in 2009, compared to $120.29 per day for Medicaid recipients in nursing facilities, with the same level of care needs. On average, the per capita daily cost of care in CIP II and COP-W during 2009 was $29.52 or 25 percent less than the cost of nursing home care.

FIGURE 7
CIP II & COP-W vs. Nursing Home Care in 2009
Average Public Costs per Day.



Source: 2009 Federal 372 Report

Appendix A

PERFORMANCE STANDARDS

A state leadership committee established the framework for assessing quality in the Community Options Program (COP). In order to ensure the goals of COP are met, person-centered performance outcomes valued by COP participants are incorporated into the acronym RESPECT:

Relationships between participants, care managers and providers are based on caring, respect, continuity over time, and a sense of partnership.

Empowerment of individuals to make choices, the foundation of ethical home and community-based long-term support services, is supported.

Services that are easy to access and delivered promptly, tailored to meet unique individual circumstances and needs are provided.

Physical and mental health services are delivered in a manner that helps people achieve their optimal level of health and functioning.

Enhancement and maintenance of each participant's sense of self-worth, and community recognition of his or her value is fostered.

Community and family participation is respected and participants are supported to maintain and develop friendships and share in their families and communities.

Tools for self-determination are provided to help participants achieve maximum self-sufficiency and independence.

RESPECT performance standards are measured by the extent to which:

- care managers identify a participant's health status and care needs, create or arrange for appropriate services to support and not supplant the help available from family, friends and the community, and monitor the performance of service providers;
- services respond to individual needs;
- participant preferences and choices are honored, and the participant is satisfied with the services delivered; and most importantly,
- participants are able to maintain a home of their own choice and participate in community life.

Appendix B

DEFINITIONS OF COMMUNITY LONG-TERM CARE PROGRAMS

COMMUNITY OPTIONS PROGRAM (COP):
The Community Options Program, administered by the Department of Health and Family Services, is managed by local county agencies to deliver community-based services to Wisconsin citizens in need of long-term assistance. Any person, regardless of age, with nursing home level of care is eligible for COP. The program began as a demonstration in eight counties in 1982 and was expanded statewide in 1986.

Funding: GPR/State = 100%

COMMUNITY OPTIONS PROGRAM-WAIVER (COP-WAIVER OR COP-W):
A Medicaid-funded waiver program which provides community services to the elderly and persons with physical disabilities who have long-term needs and who would otherwise be eligible for Medicaid reimbursement in a nursing home.

Funding: GPR/State = Approximately 40% (budgeted separately with COP GPR/state funds)
Federal = Approximately 60%

COMMUNITY INTEGRATION PROGRAM II (CIP II):
A Medicaid-funded waiver program that provides community services to the elderly and persons with physical disabilities *after a nursing home bed is closed.*

Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)

COMMUNITY INTEGRATION PROGRAM IA (CIP IA):
A Medicaid-funded waiver program that provides community services to persons with developmental disabilities who are relocated from the State Centers for the Developmentally Disabled.

Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)

COMMUNITY INTEGRATION PROGRAM IB REGULAR (CIP IB):
A Medicaid-funded waiver program which provides community services to persons with developmental disabilities who are relocated or diverted from nursing homes and Intermediate Care Facilities – Mental Retardation (ICFs-MR) other than the State Centers for the Developmentally Disabled.

Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)

COMMUNITY INTEGRATION PROGRAM IB (CIP IB)/LOCAL MATCH:
A Medicaid-funded waiver program which provides community services to persons with developmental disabilities who are relocated or diverted from nursing homes and ICFs-MR other than the State Centers for the Developmentally Disabled.

Funding: GPR/State = Approximately 40% (Community Aids, county match, or COP funds)
Federal = Approximately 60% (federal Medicaid funding)

CHILDREN'S LONG TERM SUPPORT WAIVERS (CLTS-WAIVER):
A Medicaid-funded waiver program that serves children and persons under the age of 22 who have a developmental disability, physical disability and those who have a severe emotional disturbance. CLTS waivers provide funds that enable individuals to be supported in the community.

Funding: GPR/State = Approximately 40% (state Medicaid, Community Aids, county match, or COP funds)
Federal = Approximately 60% (federal Medicaid funding)

BRAIN INJURY WAIVER:
A Medicaid-funded waiver that serves a limited number of people with brain injuries who need significant supports in the community. The person must be receiving or is eligible to receive post-acute rehabilitation services in a nursing home or hospital certified by Wisconsin Medicaid as a special unit for brain injury rehabilitation. This program began January 1, 1995.

Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)

Appendix C

QUALITY ASSURANCE AND IMPROVEMENT OUTCOMES

Wisconsin has implemented a plan to demonstrate and document quality assurance efforts, which will ensure the health, safety and welfare of community waiver program participants. The quality assurance and improvement program combines a number of activities to assess and monitor program integrity, customer safety, customer satisfaction and program quality. The information obtained is provided as feedback to local and state agencies to promote quality improvement.

PROGRAM INTEGRITY

On-site monitoring reviews were conducted for a random selection of 90 cases in 2009. In addition, 1,759 new plans received a complete review. The reviews go beyond the traditional federal requirements, which only identify payment errors, in an effort to gain in-depth information on program operation and policy interpretation. Where errors were identified, corrective action plans were implemented. For all criteria monitored, percent compliance with the waiver requirements was verified. A summary of the monitoring categories and findings are as follows:

Category: FINANCIAL ELIGIBILITY

Monitoring Components:
- ✓ *Medicaid financial eligibility as approved in state plan*
- ✓ *Cost share*
- ✓ *Spend down*

Findings: *85 percent of the factors monitored indicated no deficiency. Errors were detected in more complex areas of calculation, such as cost share and spend down. These areas have been emphasized in training and technical assistance activities. A disallowance occurred if the cost share was included in the expenses billed to the waiver.*

Category: NON-FINANCIAL ELIGIBILITY

Monitoring Components:
- ✓ *Health form*
- ✓ *Functional screen*

Findings: 72 per*cent overall compliance with eligibility was measured. No instances of incorrect eligibility determination were identified under this category, although some cases failed to contain sufficient documentation.*

Category: SERVICE PLAN

Monitoring Components:
- ✓ *Individual Service Plan (ISP) developed and reviewed with participant*
- ✓ *Services waiver allowable*
- ✓ *Services appropriately billed*

Findings: 93 *percent of factors were in compliance. In a small percentage of the cases, incorrectly identified services or the omission of identified services within the ISP was noted. Only the inclusion of non-allowable costs resulted in negative findings and a disallowance of state/federal funding.*

Category: SERVICE STANDARDS AND REQUIREMENTS

Monitoring Components:
- ✓ *Waiver-billed services met necessary standards and identified needs*
- ✓ *Care providers appropriately trained and certified*

Findings: 87 *percent of factors were documented as error free. Documentation deficits accounted for many of the negative findings under this category. Disallowances were taken if standards had not been met.*

Category: BILLING

Monitoring Components:
- ✓ *Services accurately billed*
- ✓ *Only waiver allowable providers billed*
- ✓ *Residence in waiver allowable settings during billing period*

Findings: *89 percent compliance was found in these categories. Disallowances were taken.*

Category: SUBSTITUTE CARE

Monitoring Components:
- ✓ *Contracting requirements have been met*
- ✓ *Only waiver allowable costs calculated and billed*

Findings: *92 percent overall compliance was found. Documentation or errors due to room and board versus care and supervision were evidenced in a few cases. Residential care has proven to be a challenging area for services providers and is being addressed with technical assistance and training. Disallowances were taken.*

CORRECTIVE ACTION

In addition to a wrap-up meeting following a monitoring visit, a written report of each monitoring review was provided to the director of the local agency responsible for implementation of the waiver. The report provides the agency with a list of health or safety issues, indicating where action is needed at the local level. The reports also cited errors or deficiencies and required that the deficiency be corrected within a specified period of time, between 1 and 60 days. Follow-up visits were conducted to ensure compliance when written documentation was insufficient to provide assurance. Results from the consumer outcomes and satisfaction surveys are written in the report to present an overview of the county system and identify trends in service areas.

Where a deficiency correlated with ineligibility, agencies were instructed to correct their reimbursement requests. In addition, agencies were required to develop a plan to modify their practices. Disallowances were taken where retroactive corrections could not be implemented. The total disallowance within those 12 counties was **$29,390**.

Funding was disallowed in areas that included billing of non-waiver allowable services, lack of documentation for billed services, insufficient documentation or non-waiver allowable room and board costs, billing during a period of participant ineligibility for waiver services (temporary institutionalization), and inaccurate collection of cost share.

PROGRAM QUALITY

During 2009, 90 randomly selected participants responded to 22 questions during in-person interviews regarding satisfaction with waiver services. Both direct responses and reviewer assessments of those responses were recorded.

The factors studied regarding care management services were:
- ❑ Responsiveness to consumer preferences
- ❑ Quality of communication
- ❑ Level of understanding of consumer's situation
- ❑ Professional effectiveness
- ❑ Knowledge of resources
- ❑ Timeliness of response

The factors studied for in-home care were:
- ❑ Timeliness
- ❑ Dependability
- ❑ Responsiveness to consumer preferences

The factors studied for persons living in substitute care settings were:
- ❑ Responsiveness to consumer preferences
- ❑ Choices for daily activities
- ❑ Ability to talk with staff about concerns
- ❑ Comfort

Table 20 combines and summarizes the findings of the survey.

Table 20
Program Quality Results

SATISFACTION CATEGORY	PERCENTAGE OF POSITIVE RESPONSES
Care manager is effective in securing services	94%
Good communication with care manager	94%
Care manager is responsive	94%
Active participation in care plan	92%
Satisfaction with in-home workers	92%
Substitute care services are acceptable	92%
Satisfaction with substitute care living arrangement	89%

Source: 2009 Quality Monitoring Reviews.

CONTINUOUS QUALITY IMPROVEMENT PROJECTS

The information collected from various quality assurance efforts was incorporated into a variety of ongoing quality improvement projects. Examples of those activities are listed below:

- Quarterly completed review and corrections of valid Medicaid numbers.
- Utilized enhanced data collection and reporting formats to identify target areas for local monitoring, training and technical assistance.
- Produced and distributed case specific fiscal reports containing potential correctable reporting errors.
- Continued revisions to Medicaid Waivers Manual and made available to local agencies via the Department's website
- Provided training and technical assistance on the Long Term Care Functional Screen
- Provided training and technical assistance on the management of complex funding sources
- Developing a data base of decisions made through the Hearings and Appeals process.
- Developing a link to the Division of Quality Assurances data on findings in alternate care facilities.
- Developing a data base of registered service providers with/without provider agreements

We gratefully acknowledge the efforts of County Community Options Program Lead Agencies to report COP and waiver activities and expenditures completely and accurately, since this information is the foundation for the data compiled in this report. Questions may be directed to:

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